PRINTED: 7/13/2023 FORM APPROVED 2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) NAME OF PROVIDER OR SUPPLIER: TITUSVILLE HEALTHCARE AND R CENTER		(XI) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER 395901 REHABILITATION	N NUMBER: STREET ADDRESS,				(X3) DATE SURVEY COMPLETED: 11/07/2022	
STATE LICENSE NUMBER: 331102							ı	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE	
F 0000	Findings of an Abbreviated Complaint Survey completed on November 7, 2022, at Titusville Healthcare and Rehabilitation Center, identified no deficient practice, related to the reported complaint allegations under the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.		F 0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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Certified End Page

TITUSVILLE HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 331102 SURVEY EXIT DATE: 11/07/2022

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY